Claims X
Travel
Claim form

ReddiFund Mutual Benefit Fund Discretionary Trust.
If you need assistance with filling out this form, contact us on 1300 375 723 or claims.aus@claimsx.com.au

Important information

The issue of this claim form does not indicate acceptance of the claim. To assist us in assessing your claim, please:

1. Fully complete this form and supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents may result in a delay in assessing your claim.
2. Provide a comprehensive description of the circumstances of the loss, completing all relevant sections.
3. Provide additional supplementary information on a separate page if there is not enough space on this claim form.
4. Forward the completed claim form to Claims X at claims.aus@claimsx.com.au.

Traveller's details

Full name:

Phone: Email:

Residential address:

State: Postcode:

Occupation:

Date of birth:

Banking details

Account name:

BSB:

Account number:

Travel agent

Name of agent:

Phone:

Date of booking:

Date of departure: Date of return:

Have you made previous claims for travel insurance? If **yes,** please provide details: ☐ Yes ☐ No

Name of insurer	Date of claim

Cancellation claims

Please attach the following documents which are required in support of your claim;

- Travel Agent's letter confirming details of tour costings and cancellation charges.
- Copy of the original Travel itinerary, evidencing dates of travel to and from your travel destination.
- Doctor's Certificate (see Medical Certificate).
- Transport Provider's Reports.

Reason for cancellation:

Date of cancellation:

Where cancellation was due to accident, illness or death, please state the name of the person whose accident, illness or death necessitated the cancellation.

Name: Relationship to insured:

Amount claimed for recoverable prepaid travel costs: $

Hire Car Excess claims

Please attach the following documents which are required in support of your claim;

- Copy of your signed contract from the Hire Car Company, confirming the terms & conditions of the car hire.
- Copy of the vehicle incident/collision report made to the Hire Car Company.
- Receipt and Invoice to evidence the Hire Car Excess amount paid to the Hire Car Company.
- Copy of the original Travel itinerary, evidencing dates of travel to and from your travel destination.
- Copy of the Police report (if applicable)

Version (how the accident occurred):

Date of accident:

Location of the accident:

Who was responsible for the accident:

Name: Relationship to insured:

Amount claimed for Hire Car Excess paid: $

Luggage and personal effects

The following documents are required in support of your claim – Please tick when attached

- ☐ Copy of your Travel itinerary, evidencing dates of travel to and from your travel destination
- ☐ Police or responsible authority's report
- ☐ Original purchase receipts/proof of ownership
- ☐ Quotation for repair of damage
- ☐ Transport provider's reports

Date of loss:	Time:	☐ AM	☐ PM
Location:	Country:		

Please state exactly what happened:

What action did you take to recover the lost article?

Which responsible authority e.g. Police was notified?

Date of loss:	Time:	☐ AM	☐ PM
Location:			

Are your home contents insured?

Name of insurer:	Policy number:

Are you a member of a Private Health Fund?

Name of fund:	Policy number:

Please note: If you are entitled to recover losses from any other insurance policy, or other source, please do so and give details of amounts recovered.

Full description of article(s) and details of loss or damage where applicable.

Place of purchase:

Date of purchase:

Original date of purchase:

Amount claimed:

Medical emergency and additional expenses claim

The following documents are required in support of your claim - Please tick when attached

- ☐ Original medical/hospital accounts
- ☐ Accounts in support of accommodation expenses
- ☐ Medical certificates supporting need for altered travel plans
- ☐ Copy of the original Travel itinerary, evidencing dates of travel to and from your travel destination

Date of accident/illness circumstances:

Date of loss: Time: ☐ AM ☐ PM

Particulars of claim:

If your claim arises from injury or illness, please specify the nature of such injury or illness:

Name of person whose injury or illness caused additional expenditure:

Their relationship to you:

Has the injury or illness occurred before? If **yes**, please supply the following details: ☐ Yes ☐ No

Usual doctor's name:

Phone: Date of last visit:

If additional expenses have been incurred as a result of an accident, illness or death of a person in Australia, please state their relationship to you.

Expenditure for which reimbursement is claimed	Service	Amount claimed
e.g. Dr J Smith, Bali Hospital etc.		

Additional expenses	Service	Amount claimed

Cancellation/loss deposits (please attach documents from your travel agent showing cancellation charges)	Service	Amount claimed

Usual Medical Practitioner

With regards to medical, cancellation and/or additional expenses:

Name of usual Doctor:

Address of usual Doctor:

State: Postcode: Phone:

Authority and declaration

☐ I wish to report this incident, but do not want to claim against the discretionary trust at this time:

☐ I submit this information in support of a formal claim against the Trust

1. I, _____ declare that the information provided by me in relation to this claim is true and complete.
2. I, _____ authorise any doctor, dentist, physiotherapist, company, other legal entity, person, service provider to disclose to Claims X Pty Ltd all information associated with my current claim.
3. I understand that the claim may be declined if the information supplied is untrue and I have not provided all relevant facts.
4. I agree to supply any further information that may be requested of me in connection with my claim.
5. I have read and accept the Privacy Collection Statement provided with this form and Claims X Pty Ltd's Privacy Policy.
6. Where I have provided information about other individuals, I have made those persons aware of the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy provided with this form and I have obtained their consent to the information being provided in accordance with the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy.

Signature:

Please print name:

Dated:

Attending physician's statement (to be completed by your attending physician)

The insured is responsible for completion of this form without expense to the company.

Patient's name:

Patient's address:

When did the patient suffer the injury?

What were the circumstances surrounding the injury?

When did the patient first receive medical treatment?

Please give a complete diagnosis of this condition.

Please give results of any objective findings – (Detail tests done and findings)

Test	**Findings**
X-Rays:	
Other tests:	

Was the patient confined to hospital? If **yes**, please advise the name and address of hospital: ☐ Yes ☐ No

Period of confinement: From To

What other treatment has the patient undergone?

What other treatment is required?

History

Was there a previous history or a similar condition? If **yes**, please state the condition and advise when previous treatment was given: ☐ Yes ☐ No

How long have you known the patient?

Are you the regular General Practitioner? If **not**, please advise who is? ☐ Yes ☐ No

Degree of disability

When was the patient obligated to cease work?

If the patient is still unfit for work, when approximately will the patient be able to resume?

If the patient has recovered, when was the patient able to resume work?

Are there any underlying conditions affecting recovery from the current condition? If **yes**, please advise the nature of underlying conditions and how they affect disability and recovery: ☐ Yes ☐ No

Please advise names and addresses of other treating physicians:

If you have terminated treatment, please advise the date:

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Is there permanent disability at present? If **yes**, please explain, giving estimated percentage of loss of function:

Doctor's declaration

- I hereby certify that I have personally examined the abovenamed claimant and that in my opinion the statements made by me in this claim form are true and correct.
- I have read and accept the Privacy Collection Statement provided with this form and Claims X Pty Ltd's Privacy Policy.
- Where I have provided information about other individuals, I have made those persons aware of the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy provided with this form and I have obtained their consent to the information being provided in accordance with the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy.

Name:

Provider Number:

Qualifications:

Telephone:

Address:

Email Address:

Date:

Signature:

Collection Statement under the Privacy Act 1988 (Cth)

In accordance with the Privacy Act 1988 (and subsequent amendments), Claims X Pty Ltd ABN 57 649 962 701, AFSL 530894 (we, our, us, Claims X), draws your attention to the following:

- We may collect personal information or sensitive information about you.
- We are collecting the information principally for the purpose of claims handling and settling services.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, other parties which may assist us in assessing your claim, agents and Claims X related group companies, such as Howden Insurance Brokers (Australia) Pty Ltd ABN 79 644 885 389, AFSL 539613 (Howden) and Alternative Risk Management Services Pty Ltd ABN 70 649 963 191 (ARMS). Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- Our related group companies may provide you with information about other products and services including but not limited to an alternate risk management solution offered through ARMS. ARMS and Howden will use and disclose your information to assist in the administration, promotion and risk management of the applicable discretionary trust.
- Please read our Privacy Policy on https://www.howdengroup.com/au-en/privacy-policy for further information in relation to how we and our related group companies collect, store and use your information. You may also request a copy from our privacy officer whose details are below.
- If you would like further information contact our privacy officer on the contact details below:

  Post: Claims X Pty Ltd
  Level 23, 20 Bond Street
  Sydney, NSW 2000

  Email: privacy.pacific@howdengroup.com

- By providing this information, you agree to us collecting, using and disclosing your personal or sensitive information as outlined in this Collection Statement and our Privacy Policy.
- If you do not provide all or part of the information requested, we may be unable to process your application, administer your claim or provide other required services, or your application for insurance or membership of a discretionary trust arrangement may be declined or you may prejudice your insurance cover or cover under a discretionary trust.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988 (Cth).
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided as they occur.
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's prior consent.